

U. S. NUCLEAR REGULATORY COMMISSION  
REGION I  
SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE  
NIAGARA MOHAWK POWER CORPORATION  
NINE MILE POINT NUCLEAR STATION, UNIT I  
JUNE 20, 1983

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## I. INTRODUCTION

### 1.1 Purpose and Overview

The Systematic Assessment of Licensee Performance (SALP) is an integrated NRC Staff effort to collect the available observations on an annual basis and evaluate licensee performance based on those observations with the objectives of improving the NRC Regulatory Program and licensee performance. The assessment period for this report is May 1, 1982 through April 30, 1983.

The prior SALP assessment period was May 1, 1981 through April 30, 1982. Significant findings of that assessment were provided in the applicable Performance Analysis Functional Areas (Section IV).

Evaluation criteria used during this assessment are discussed in Section III below. Each criterion was applied using the "Attributes for Assessment of Licensee Performance" contained in NRC Manual Chapter 0516.

### 1.2 SALP Attendees:

R. W. Starostecki, Director, Division of Project and Resident Programs

H. B. Kister, Acting Branch Chief, Project Branch No. 2

J. P. Durr, Acting Branch Chief, Engineering Programs Branch

S. D. Hudson, Senior Resident Inspector, Nine Mile Point Unit 1

R. A. Hermann, Licensing Project Manager, Office of Nuclear Reactor Regulation

### 1.3 Background

#### 1.3.1 Licensee Activities

The plant remained out of service for the entire assessment period due to the replacement of the recirculation (recirc) system piping and safe ends. This repair required the reactor core and control rod blades to be off-loaded to the spent fuel pool. Just prior to the end of the period, the control rod blades were reinstalled in the reactor vessel and core loading began.

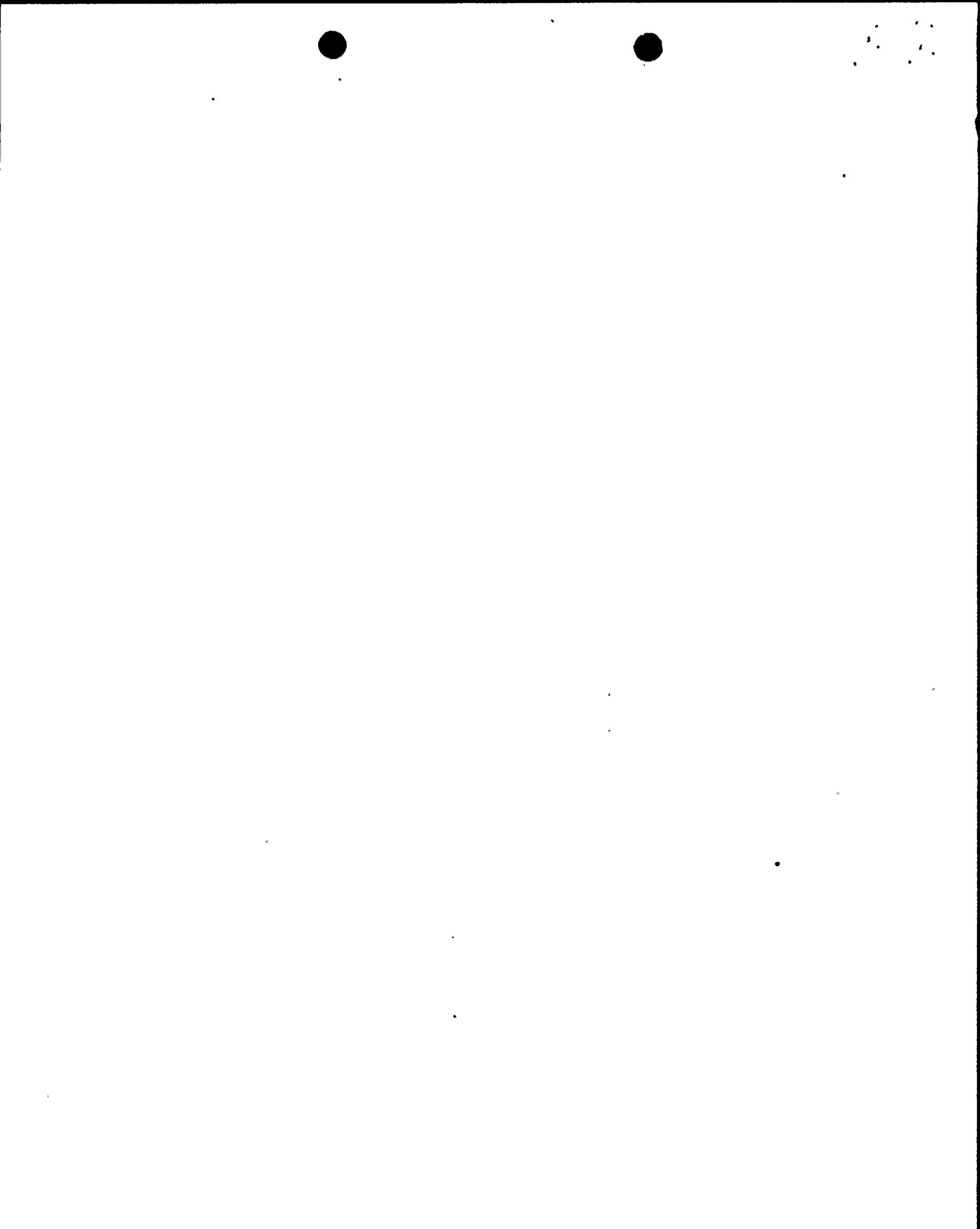
#### 1.3.2 Inspection Activities

One NRC resident inspector was onsite during the assessment period. The routine resident inspection program was modified to emphasize the review of ongoing recirc piping replacement activities and the associated radiological controls. The total NRC inspection for the period were 2224 hours (resident and region based), with a distribution as shown in Table 2.



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Tabulations of Violation and Inspection Activities are attached as Tables 3 and 4 respectively.



II. SUMMARY OF RESULTS

NINE MILE POINT NUCLEAR STATION, UNIT 1

<u>FUNCTIONAL AREAS</u>	<u>CATEGORY 1</u>	<u>CATEGORY 2</u>	<u>CATEGORY 3</u>
1. Plant Operations		X	
2. Radiological Controls Radiation Protection Radioactive Waste Management Transportation Effluent Control and Monitoring		X	
3. Extended Outage Work	X		
4. Maintenance	X		
5. Surveillance (Including Inservice and Preoperational Testing)			Insufficient Basis
6. Fire Protection	X		
7. Emergency Preparedness			Insufficient Basis
8. Security & Safeguards	X		
9. Licensing Activities	X		

Overview

This assessment reflects the board's evaluation based on a period during which the plant was shutdown for replacement of the recirculation system piping. The plant performance regarding the mechanical and radiological aspects of this extended outage is considered excellent. The plant's well managed security organization was able to control the large number of workers onsite without incident. The refueling operation was conducted in a very professional manner.

Subsequent to the assessment period, plant start-up operations were noted to proceed smoothly. However, the NRC will continue normal inspection activities to verify re-establishment of operating skills and continuation of radiological controls measures established during the outage.



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### III. CRITERIA

The following evaluation criteria were applied to each functional area:

1. Management involvement in assuring quality.
2. Approach to resolution of technical issues from a safety standpoint.
3. Responsiveness to NRC initiatives.
4. Enforcement history.
5. Reporting and analysis of reportable events.
6. Staffing (including management).
7. Training effectiveness and qualification.

To provide consistent evaluation of licensee performance, attributes associated with each criterion and describing the characteristics applicable to Category 1, 2, and 3 performance were applicable as discussed in NRC Manual Chapter 0516, Part II and Table 1.

The SALP Board conclusions were categorized as follows:

Category 1: Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used such that a high level of performance with respect to operational safety or construction is being achieved.

Category 2: NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and are reasonably effective such that satisfactory performance with respect to operational safety or construction is being achieved.

Category 3: Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appeared strained or not effectively used such that minimally satisfactory performance with respect to operational safety and construction is being achieved.



#### IV. PERFORMANCE ANALYSIS

##### 1. Plant Operations (30%)

The plant did not operate during the assessment period due to the recirculation pipe replacement effort. The fuel and control rods were offloaded and most of the surveillance program was suspended. The resident inspector however, continually observed the licensee's performance in maintaining overall control of plant status and other outage activities.

During the previous assessment period, there were three events involving improper removal of equipment from service. The licensee's actions in this area appear to have been effective since no further events of this type have occurred. However, toward the end of this period, a set of jumpers were found installed when the Jumper log indicated they had been removed, and a set of uncontrolled lifted leads were identified indicating a need for increased emphasis in this area with the plant returning to an operational status:

Licensee management continues to be involved in enhancing the quality of plant operations. As an example, a complete review of all operating procedures has been initiated. This review includes a field verification of valve line-ups and labeling of valves and equipment. Further, in response to questions by the resident regarding close out of modification packages, the Quality Assurance Department took the initiative and recently completed an extensive effort to verify proper close out of safety related modifications performed from 1975 to 1979, to ensure that drawings and procedures have been updated and that quality control records are complete.

On the other hand, the resident inspector identified several instances where Inspection and Enforcement Circulars had not been reviewed by the plant staff for applicability for extended periods of time (up to four years) and when reviewed, corrective actions had not been fully implemented. Also, twice during a 13 month period (once during the previous period) the reactor water cleanup filter sludge tank was overflowed apparently as a result of a level gauge problem, and caused extensive contamination of the Reactor Building Ventilation system and several areas in the Reactor Building. This event is further discussed in functional area No. 2.

Onsite review committee is adequately staffed and appears to be functioning in accordance with established procedures. One exception to this was a failure to review a series of procedures for the removal and replacement of recirculation system nozzle safe-ends early in the outage. This however appeared to be an isolated case.

Operations staffing continues to exceed requirements and training is adequate.



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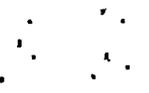
In summary, licensee management is involved in a continuing effort to improve the quality of plant operations however, continued attention is necessary to assure proper control of jumpers and lifted leads and ensure a more prompt review of NRC communications by the plant staff.

Conclusion

Category 2

Board Recommendations

Continue routine inspection program to verify establishment of normal operating skills.



## 2. Radiological Controls (15%)

During the previous assessment periods problems were evident in radiation protection procedure adherence, waste management audits, effluent controls and monitoring, and failure to fulfill commitments to the NRC relating to HP Appraisal findings. A Category 3 performance rating was assigned.

During the current assessment period, four inspections were conducted by Region I Radiation Specialists. The Resident Inspector continued to review ongoing radiological controls activities. Three Severity Level IV violations were identified in the area of radiation protection adherence: two violations involving failure to adhere to radiation work permits, and one violation involving failure to inventory a number of radioactive sources.

The review of the licensee's Radiation Protection Program during the assessment period identified a number of deficiencies in the licensee implementation of documented commitments made to upgrade the program in response to Health Physics Appraisal findings. This is a problem from the previous assessment period. These commitments primarily involved establishment and implementation of additional program procedures. The review of the licensee's technician training program indicated that the licensee had not established a program to ensure that technicians were adequately trained and qualified in their procedural responsibilities. In addition, the licensee had not established a program to train technicians in new procedures or changes to existing procedures. The licensee has taken action to resolve these matters. The licensee performed an audit of Health Physics Appraisal commitments to identify other commitments which may have been missed; is in the process of establishing a shift technician training program; is establishing a long term technician training and retraining program; and is establishing means to ensure technicians are trained in new procedures and changes to procedures. In addition, the licensee hired a contractor to organize and track closure of Health Physics Appraisal Items. The licensee also created and staffed the position of technician-compliance to track future commitments.

A review of inventory and control of radioactive sources with respect to licensee corrective actions for Health Physics Appraisal findings indicated that the licensee had not implemented procedures established to address appraisal findings in this area. This finding resulted in a recurrent violation for failure to inventory sources. No documentation was found to indicate that the individual performing the inventory had been trained in and qualified in the procedure requirements. The licensee took action to correct this matter.

A review of the licensee's establishment and implementation of ALARA controls for replacement of recirculation safe-ends, indicated that the licensee implemented very good controls for the replacement.



Although some minor concerns were identified, the licensee adequately addressed these concerns. However, the review of the licensee's Station ALARA Program with respect to commitments provided in response to an Immediate Action Letter issued as a result of Health Physics Appraisal findings indicated the licensee had not implemented the ALARA Program development commitments. The licensee has contracted for ALARA Program development services and had provided program completion re-commitments.

A review of licensee audits indicated that the licensee was not performing reviews of Radiation Protection Program procedures in accordance with established schedules. The licensee took action to review the procedures. Following NRC identification of failure to meet commitments, the licensee initiated an audit of Health Physics Appraisal commitments.

The licensee is currently performing a comprehensive review of the onsite and corporate Radiation Protection and Chemistry Organization. Job Task analyses are being performed in an effort to define the size of organization needed. In addition, the licensee had doubled the size of the organization since the Health Physics Appraisal and has also increased the size of the training staff providing radiological controls training at the site.

The review of the licensee's Radioactive Waste Management Program indicated the licensee has established a formal, dedicated Radioactive Waste Organization. The licensee is currently developing job position descriptions for the organization.

The review of radioactive waste handling procedures indicated the licensee has established procedures for waste packaging, handling and transportation in response to a Health Physics Appraisal finding. However, a procedure established to ensure all radioisotopes have been identified in radioactive waste, also in response to an appraisal finding, did not provide adequate guidance for this activity. The licensee took action to correct this matter.

During this assessment period, the licensee experienced a second spill of radioactive material from the Reactor Water Clean-up System sludge tank. The tank overflow, caused by a faulty tank level indicator resulted in contamination of duct work and floors in the Reactor Building. The previous spill occurred on February 4, 1982 and resulted in the expenditure of about 8.5 person-rem in Reactor Building decontamination. The licensee's corrective actions after the first event did not preclude recurrence.

The review of the licensee's radioactive waste transportation program indicated that the licensee established and implemented a training program for personnel involved in radioactive waste handling operations. The licensee established lesson plans to provide training required by IE Bulletin 79-19. However, the lesson plan did not



provide for training of radiation protection and chemistry technicians in procedures involving radioactive waste packaging, handling, and shipping. The licensee took action to ensure the training requirements of IE Bulletin 79-19 are implemented.

In summary, although there were recurring problems from the previous assessment periods, management attention in solving these problems is now evident and significant strides have been made. Commitments are now being tracked by a consultant, and management is being continuously appraised of progress. Also, an organizational structure is being developed for this department that will provide better overall control of radiological activities. Further, Radiological controls for the recirculation pipe replacement were excellent. ALARA was evident in that total exposure was significantly less than the original estimate. This was accomplished by decontamination of the recirculating piping, extensive use of shielding, mockup training, and close monitoring and control of worker exposure.

Conclusion

Category 2

Board Recommendations

None



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### 3. Extended Outage Work (41%)

In March 1982, during a hydrostatic test of the reactor vessel, cracks were discovered in two reactor vessel safe ends for the recirculation (recirc) system. Since these safe ends were furnace sensitized during manufacturing, the licensee had been conducting an augmented inservice inspection program since 1979. Plans were in place for eventual replacement of the safe ends in the event that intergranular stress corrosion cracking was found.

During the period of April thru September 1982, the licensee conducted additional ultrasonic testing of the piping welds in the recirculation, shutdown cooling, core spray, and emergency condenser systems to further define the extent of the cracking. Multiple indications of intergranular stress corrosion cracking (IGSCC) were identified in the recirc system piping although, no indications of IGSCC were found in the other three systems examined. To avoid hundreds of person-rem of exposure and the need for a second extended outage for replacement of the recirc system safe ends, the licensee decided that the most prudent course was to replace all of the recirc system piping using material not susceptible to IGSCC.

A great deal of management attention and resources have been devoted to assure the quality of the recirc piping replacement. The replacement was performed by contractors who also supplied an extensive on-site Quality Assurance function. Prior to beginning work, the licensee audited the contractors QA program to determine its compliance with 10 CFR 50, Appendix B. Additionally, the licensee supplemented its own on-site Q. A. staff to provide a separate overview of the contractor's work. The management of the replacement was supervised by a dedicated staff engineer at the site and he was assisted by the seven other engineers. At least one of these engineers was always on-site to provide a management review of ongoing operations.

The licensee established special precautions to ensure that the radiation exposure to the workers was maintained as low as reasonably achievable (ALARA). The recirc loops were chemically decontaminated prior to the removal of the piping. This lowered the general area radiation levels in the drywell. Specifically, designed shielding was installed into the reactor vessel and the safe ends to minimize the radiation shine from the reactor. Video cameras were used to allow remote monitoring of piping, cutting and welding in the highest radiation areas. The workers were trained on full scale mock-ups. This increased their proficiency and decreased the time needed to perform a task and the radiation exposure received. Weekly, the licensee compared the radiation exposure received to pre-established limits to determine the effectiveness of the ALARA program.



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The licensee was responsive to the NRC's concerns about dissimilar metal welding, welders qualifications, repair of the cut on the reactor vessel nozzle, and a final stress analysis of new piping. In each case, a timely and technically sound proposal was initiated to address the concern. The licensee was also helpful in the evaluation of the generic implications of IGSCC in large diameter recirc system piping.

Three violations were identified which were associated with the piping replacement. The licensee corrective action was prompt and effective. This was demonstrated by the fact that the violation did not reoccur. Early in the outage, the licensee's Q. A. department issued a "show-cause" nonconformance report to the prime contractor based on several examples of programmatic problems with the implementation of the contractor's Q. A. program. The contractor's corrective action based on a meeting with corporate management, was effective in preventing reoccurrence.

The NRC also performed an independent non-destructive examination of selected welds performed in the recirc system. This inspection included radiography and ultrasonic examination of welds for unidentified defects and a review of the licensee's radiographs of selected welds. No defects were identified.

The resident inspector witnessed portions of the reloading of the control rod blades and reactor core. There was no licensee event reports concerning refueling and only one violation of fuel handling procedures concerning the control of material over the open reactor vessel.

Prior to commencing the reloading operation, the licensee prepared a master checklist of surveillance tests and preventive maintenance items that needed to be completed. The inspector verified that the list addressed all items required by Technical Specifications and on a sampling basis, that the items had been properly completed.

The work hours of the operators conducting refueling allowed for breaks to prevent fatigue from causing personnel errors. Except for minor equipment failures of the refuel bridge and grapple, the refueling proceeded swiftly yet safely.

#### Conclusion

Category 1

#### Board Recommendation

None



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#### 4. Maintenance (2%)

The predominant effort during this assessment period has been the replacement of the Recirculation System piping. This activity is discussed under Functional Area 3, Extended Outage Work.

During the previous assessment period, both the NRC and the licensee's Quality Assurance Department noted deficiencies in the documentation of safety-related maintenance. In June, 1982 Niagara Mohawk issued a major revision to the Administrative Procedure for controlling corrective maintenance. The revision increased the responsibilities of the supervisors to review completed work requests. The work request also requires final acceptance by Quality Control and the shift supervisor prior to returning the equipment to service. A November 1982 audit of the work request system revealed only one deficiency which indicates a significant improvement over the previous period.

The licensee has an established preventative maintenance program for safety related equipment such as motor operated valves, breakers, and M.G. sets, emergency diesel generator engines and mechanical snubbers which has enhanced the reliability of this equipment.

With regard to staffing, Niagara Mohawk has recently authorized the position of maintenance coordinator for each of the three maintenance areas (I&C, electrical, mechanical). Although still vacant, the duties will include scheduling, material procurement, and equipment tagout coordination and should improve equipment down time, and work force efficiency.

In summary, management involvement is evident in the maintenance area. Improved preventative maintenance along with increased control and coordination have resulted in a quality program.

#### Conclusion

Category 1

#### Board Recommendation

None



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5. Surveillance (2%)

During the assessment period, many surveillance tests were not required to be completed since the reactor core was off-loaded to the spent fuel pool. Although the licensee continued to perform some of these tests, such as periodic testing of the emergency diesel generators, Region I decided to suspend routine inspections in this area. One region-based inspector examined some of the areas of the licensee's inservice inspection program.

Based on the limited scope of inspections performed, an overall evaluation of this functional area cannot be made.

Prior to start-up in June 1983, the licensee performed all surveillance tests required for a refueling outage, including the containment integrated leak rate test and reestablished the normal schedule of periodic testing.

Conclusion

Insufficient Basis

Board Recommendation

Resume routine inspection activities of this functional area.



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6. Fire Protection and Housekeeping (3%)

During the current assessment period, one programmatic inspection was performed by a region based inspector. Additionally, the resident inspector examined fire protection activities on a routine basis.

Although the licensee has committed considerable resources to the fire protection program, the administrative details of the program were found to require improvement in several areas.

The licensee had previously committed via correspondence with the NRC to comply with the BTP 9.5-1 requirements or was required to comply based on 10 CFR 50.48. During the inspection, the licensee agreed to correct the above deficiencies. Based on the number of minor problems noted, additional management attention in these areas appears warranted.

The procedure for training of the fire brigade did not specify the frequency of all of the training required by 10 CFR 50, Appendix R. However, it was noted that fire brigade training and drills are conducted on regular basis in excess of that required by Appendix R. The facilities for practical training were noted to be excellent.

The fire brigade consists of five shifts each manned by five full time firefighters. Each shift attends 4 days of training every five weeks. The licensee also employs a full time training instructor devoted to fire brigade training.

Housekeeping during this period was considered good taking into account the extensive work that was performed. The effectiveness of the licensee's fire protection and housekeeping program was demonstrated by the fact that no major fires occurred during the assessment period when considerable welding and cutting was performed in association with the recirc piping replacement.

Conclusion

Category 1

Board Recommendations

None



5 4

7. Emergency Preparedness

During the current assessment period, there was one announced special safety inspection of emergency preparedness activities.

An inspection of the Public Prompt Notification System was conducted on March 2-4, 1983 to verify installation, testing, and documentation. No deficiencies were identified by the inspector. Records were complete and well maintained. Management policies were strictly adhered to and verified.

There were no violations or reportable events during this assessment period. The licensee had requested and was granted an exemption from the annual emergency preparedness exercise requirement. The annual exercise was delayed until September, 1983.

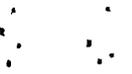
A follow-up inspection has been scheduled for June, 1983 to verify the licensee's corrective actions identified during the Emergency Preparedness Implementation Appraisal which was conducted on August 17-20, 1981.

Conclusion

Based on the above, the overall performance of the licensee during this assessment period cannot be evaluated.

Board Recommendation

The licensee performance in this area will be examined during the annual exercise in September, 1983.



8. Security and Safeguards (5%)

During the assessment period, two routine physical protection inspections were accomplished by region-based inspectors. Routine resident inspections continued throughout the assessment period. No violations were identified and no 10 CFR 73.71 Safeguards Events were submitted by the licensee.

The development and continued enforcement of strong management controls is evidenced by no violations of regulatory requirements for a two-year period. Management involvement was evidenced by planned program improvements that include: (1) completing the upgrade of the access control system hardware/software project; (2) allocation of additional I&C technicians (estimated increase from 3 to 9) dedicated and assigned to the security organization; (3) procurement and assignment to the security organization of a mobile communications van to enhance communications effectiveness in the event of a site radiological and/or security emergency; (4) employment and assignment of an additional Security Area Investigator to the security organization; (5) design/layout of additional security facilities coincidental with the ongoing construction of Nine Mile Point, Unit 2; (6) planned procurement in FY 84 of a Security Organization Central Alarm Station Simulator to be set up as a dedicated training/qualification module to improve CAS/SAS Operator performance; and (7) planned development of the security organization training program so that all shift personnel can be assigned to a dedicated training cycle (40-hour training week) each five weeks.

Program assessment revealed strong interface involvement by both corporate and site security management in directing the security organization. Licensee cooperation was evident in their responses to NRC recommendations made during inspection visits and telephone conversations.

All security personnel appeared to be knowledgeable in their assigned duties. The Guard Training and Qualification Program is progressing on schedule. The program is well defined and implemented with dedicated and professional personnel. Classroom instruction was highly professional. Lesson plans and tests were meaningful, and they appeared to be achieving the desired performance objectives.

These program improvements combined with a track record of sustained compliance with regulatory requirements for two consecutive years illustrate balanced management effectiveness.

Conclusion

Category 1

Board Recommendation

None



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9. Licensing

Niagara Mohawk's approach to technical issues are indicative of the licensee's technical understanding of most issues. Niagara Mohawk's rather large well qualified engineering staff, in concert with an astute licensing staff assures that most engineering work, either done in house or performed under its direction by contractors, adequately addresses complex technical issues. An exception to this is the licensee's handling of the masonry walls issue. As a result of a meeting with the licensee and exchange of information, an improvement in performance for this particular issue is expected.

With regard to responsiveness, in general, Niagara Mohawk has been responsive with regard to issues related to recirculation pipe replacement, Appendix R, and TMI items, however with regard to masonry walls and core spray distribution, responses have not been as timely as desired. These issues have been outstanding for extended periods.

Events are generally reported in a timely manner, reasonably identifying causes and corrective actions. Followup reports are generally provided when appropriate. Licensing and engineering staffing appears to be adequate, particularly as it applied to the recirculation pipe replacement.

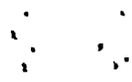
Operator license examinations were conducted during the evaluation period. This process included both written and oral examinations. Examinations were given to 17 candidates. Of these, 13 persons passed. RO licenses were issued to 4 persons and SRO licenses were issued to 9 persons.

Conclusion

Category 1

Board Recommendation

None



V. SUPPORTING DATA AND SUMMARIES

1. Licensee Event Reports

Tabular Listing

Type of Events:

A. Personnel Errors . . . . .	0
B. Design/Man./Constr./Install . . . . .	5
C. External Cause . . . . .	0
D. Defective Procedure . . . . .	0
E. Component Failure . . . . .	6
X. Other . . . . .	5
	<u>16</u>
	Total

LER's Reviewed:

LER #82-11 to 82-23                      83-01 to 83-05  
82-14 and 14 were deleted by licensee.

Causal Analysis

Three sets of common mode events were identified.

- a. LER 82-17, 18, 19, and 20 reported the failure of containment isolation valves to meet the specified value for local leak rate testing. These failures were attributed to poor design and modifications were made to improve the leakage.
- b. LER's 82-22 and 23 reported the failure of containment isolation valves to meet the specified value for local leak rate testing. These failures were attributed to dirt and corrosion in the seating area of the valves. Each valve was disassembled, cleaned, and successfully tested.
- c. LER's 82-12 and 83-03 reported the failure to meet the lower limit of detection sensitivity for radioanalysis of fish sample. A change to Technical Specifications has been submitted to revise this value to be in accordance with Regulatory Guide 8.4.

2. Investigation Activities

None



V. SUPPORTING DATA AND SUMMARIES

1. Licensee Event Reports

Tabular Listing

Type of Events:

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	Total

LER's Reviewed:

LER #82-11 to 82-23                      83-01 to 83-05  
82-13 and 14 were deleted by licensee.

Causal Analysis

Three sets of common mode events were identified.

- a. LER 82-17, 18, 19, and 20 reported the failure of containment isolation valves to meet the specified value for local leak rate testing. These failures were attributed to poor design and modifications were made to improve the leakage.
- b. LER's 82-22 and 23 reported the failure of containment isolation valves to meet the specified value for local leak rate testing. These failures were attributed to dirt and corrosion in the seating area of the valves. Each valve was disassembled, cleaned, and successfully tested.
- c. LER's 82-12 and 83-03 reported the failure to meet the lower limit of detection sensitivity for radioanalysis of fish sample. A change to Technical Specifications has been submitted to revise this value to be in accordance with Regulatory Guide 8.4.

2. Investigation Activities

None



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3. Escalated Enforcement Actions

3.1 Civil Penalties

None

3.2 Orders

Confirmatory Order dated March 14, 1983 which confirms specific implementation dates for post TMI related items.

3.3 Confirmatory Action Letters

None

4. Management Conferences

SALP Management Meeting held July 8, 1982.



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TABLE 1  
TABULAR LISTING OF LERS BY FUNCTIONAL AREA  
NINE MILE POINT NUCLEAR STATION, UNIT 1

<u>Area</u>	<u>Number/Cause Code</u>	<u>Total</u>
1. Plant Operations	1/E	1
2. Radiological Controls	1/B, 1/D, 4/X	6
3. Extended Outage Work	None	
4. Maintenance	None	
5. Surveillance	4/B, 3/C	7
6. Fire Protection	1/E, 1/X	2
7. Emergency Preparedness	None	
8. Security and Safeguards	None	
9. Licensing Activities	None	
TOTAL		16

Cause Codes:

- A - Personnel Error
- B - Design, Manufacturing, Construction or Installation Error
- C - External Cause
- D - Defective Procedures
- E - Component Failure
- X - Other



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TABLE 2  
INSPECTION HOURS SUMMARY (5/1/82 - 4/30/83)  
NINE MILE POINT NUCLEAR STATION, UNIT 1

	<u>HOURS</u>	<u>% OF TIME</u>
1. Plant Operations . . . . .	676	30
2. Radiological Controls . . . . .	336	15
3. Extended Outage Work . . . . .	918	41
4. Maintenance . . . . .	45	2
5. Surveillance . . . . .	51	2
6. Fire Protection . . . . .	62	3
7. Emergency Preparedness . . . . .	21	1
8. Security & Safeguards . . . . .	118	5
9. Licensing Activities . . . . .	0	0
10. Other . . . . .	24	1
Total	<u>2251</u>	<u>100%</u>

\* Special Nuclear Material Control - 24 hours



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TABLE 3  
VIOLATIONS (5/1/82 - 4/30/83)  
NONE MILE POINT NUCLEAR STATION, UNIT 1

A. Number and Severity Level of Violations

1. Severity Level

Deviation	0
Severity Level I	0
Severity Level II	0
Severity Level III	0
Severity Level IV	5
Severity Level V	5
Severity Level VI	0
Total	10

B. Violations Vs. Functional Area

<u>FUNCTIONAL AREAS</u>	<u>Severity Levels</u>						
	I	II	III	IV	V	VI	DEV
1. Plant Operations				1			
2. Radiological Controls				1	2		
3. Extended Outage Work				3	1		
4. Maintenance							
5. Surveillance					1		
6. Fire Protection					1		
7. Emergency Preparedness							
8. Security & Safeguards							
9. Licensing Activities							
Total				5	5		

Total Violations = 10



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(TABLE 3 Continued)

C. Summary

<u>Inspection Report No.</u>	<u>Inspection Date</u>	<u>Severity Level</u>	<u>Functional Area</u>	<u>Requirement</u>	<u>Violation</u>
82-06	May 18-21, 1982 June 22-24, 1982	5	2	Tech. Spec.	Failure to follow Radiation Work Permit
82-09	June 15-18, 1982	5	6	10 CFR 50, Appendix B	Failure to establish a fire watch
82-10	June 21-25, 1982	4	3	Tech. Spec.	Failure to SORC approved procedures for safe safe ends
82-11	Oct. 26-29, 1982	4	3	10 CFR 50, Appendix B	Failure to correctly label radiographs
82-14	Aug. 1-31, 1982	5	2	Tech. Spec.	Failure to follow Radiation Protection Procedure
83-02	Feb 1-28, 1982	4	3	10 CFR 50, Appendix B	Failure to provide acceptable procedures for installation of flanges
		5	5	10 CFR 50 Appendix B	Failure to document review of pipe hanger inspection



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(TABLE 3 Continued)

83-03	Feb. 28 - March 4, 1983	4	2	Tech. Spec.	Failure to conduct inventory of radio- active source
83-08	April 1-30, 1983	4	1	Tech. Spec.	Failure to control the use of jumpers
83-09	Apr. 12-15, 1983	5	3	Tech. Spec.	Failure to control material over the reactor vessel



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TABLE 4  
INSPECTION REPORT ACTIVITIES (5/1/82 - 4/30/83)  
NINE MILE POINT NUCLEAR STATION, UNIT 1

<u>Inspection Report No.</u>	<u>Inspection Hours</u>	<u>Areas Inspected</u>
82-06	66	Radiological Controls
82-07	141	Routine, Resident
82-08	91	Routine, Resident
82-09	62	Fire Protection
82-10	39	Modifications
82-11	30	Recirc Piping Replacement
82-12	103	Routine, Resident
82-13	34	Recirc Piping Replacement
82-14	86	Routine, Resident
82-15	58	Security
82-16	51	Inservice Inspection Recirc Piping Replacement
82-17	87	Routine, Resident
82-18	24	Nuclear Material Control
82-19	94	Routine, Resident
82-20	30	Radiological Controls
82-21	72	Routine, Resident
82-22	27	Security
82-23	79	Routine, Resident
83-01	138	Routine, Resident
83-02	107	Routine, Resident
83-03	30	Radiological Controls



TABLE 4

INSPECTION REPORT ACTIVITIES (5/1/82 - 4/30/83)

NINE MILE POINT NUCLEAR STATION, UNIT 1

<u>Inspection Report No.</u>	<u>Inspection Hours</u>	<u>Areas Inspected</u>
83-04	13	Public Notification System
83-05	--	Management Meeting
83-06	82	Routine, Resident
83-07	548	Independent Non-Destructive Examination of Recirc Piping
83-08	132	Routine, Resident
83-09	27	Radiological Controls



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TABLE 5

LER SYNOPSIS (5/1/82 - 4/30/83)

NINE MILE POINT NUCLEAR STATION, UNIT 1

<u>LER Number</u>	<u>Type</u>	<u>Summary Description</u>
82-11	30 day	Fuel leak on diesel fire pump
82-12	30 day	Failure to meet lower limit of detection sensitivity
82-13 and 14	deleted by licensee	
82-15	30 day	Removal of a fire system from service for a modification
82-16	30 day	Inadvertent discharge of radioactive water to Lake Ontario
82-17, 18, 19, 20, 21, 22, 23	30 day	Exceeded local leak rate requirement for containment isolation valves
83-01	30 day	Improperly installed wind direction indicator
83-02	10 day	Tritium found in intake water sample during reverse flow
83-03	30 day	Failure to meet lower limit of detection sensitivity
83-04	10 day	Cesium 137 found in shoreline sediment samples
83-05	prompt	Inadvertent overflow of cleanup sludge tank



100-10000-100



100-10000-100